CODE SHEET REVIEWED BY CLASS DESK ANALYST -

NAVAL AVIATION SAFETY CENTER

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Aer-21/1/2 2. A contractor's proposal for a low fuel state warning system for the FLD aircraft was rejected due to entineering features which provided only CONTAVATRPAC 00, 3dMaw 00, MAG-15

FF4-1/3040 Serial: 80/ 564

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 65, OPNAVINST 3750.60

JAN 2 0 1959

FIFTH ENDORSEMENT on VMF(AW)-513 AAR ser 2-58 concerning F4D-1 BUNO 139106 accident occurring 19 November 1958, pilot (b)

From: Commander Naval Air Force, Pacific Fleet

To: Chief of Naval Operations (OP-57)

Via: (1) Chief, Bureau of Aeronautics (AER-21)

(2) Commander, U. S. Naval Aviation Safety Center

Sub.1: VMF(AW)-513 AAR ser 2-58

1. Forwarded, concurring in the conclusions and recommendations of the Aircraft Accident Board, and in the remarks contained in subsequent endorsements.

(b) (b)

By direction

Copy to:
NAVAYSAPCEN (2) (Airmsil)
CMC (GODE AAP)
CINCPACFLIT
CG, AIRPMPPAC
CG, 3rd MAW
CO, MAG-15
CO, VMF(AM)-513
BAR, EL SEGUNDO
BAR, EAST HARTPORD

OIC, NPU, EL CENTRO

FF13-5 F9 JAN 1959

FOURTH ENDORSEMENT on VNF(AW)-513 AAR ser 2-58 concerning FAD-1, Bullo 139106, accident occurring 19 November 1958, pilot (b)

From: Commanding General, Aircraft, Floot Marine Force, Pacific To: Chief of Navel Operations (Op-57)

Via: (1) Commander, Naval Air Force, Parific Fleet

3) Commander, U. S. Naval Aviation Safety Center

Subj: Major Aircraft Accident Report, case of Captain (b) (6) (b) (6) USMCR

CO, VMF(AW)-513 DinC, NFU, El Centro BAR, East Hartford, Conn. BAR, El Segundo, Calif

SPECIAL HANDLING TYPUTRED in accordance with para 65 of OTNAV INST 3750.60

61:0M:kef DEC 24 1958

THIRD ENGORSHIENT on VIF(AV)-513 AAR ser 2-58 concerning F4P-1, 139106, accident occurring 19 November 1956, pilot (b) (6)

From: Commanding Ceneral, 3d Marine Aircraft Wing

Via: (1) Commanding General, Aircraft, Fleet Carine Force,

(2) Commander, Naval air Force, Pacific Fleet

(3) Chief, Bureau of Aeronautics (MA-61)

(4) Commander, U. S. Naval Aviation Safety Center

Subj: VMF(A!)-513 AAR ser 2-58.

1. Forwarded concurring in the report and first endorsement, as modified by the second endorsement.

2. Filot factor appears to be the dominant factor in this major aircraft accident. The truly professional pilot, relatively to bord note in the sold, upon observing the unusual internal fuel sold respected his primary attention to fuel menitoring/fuel management rather than to five additional minutes of section tactics. Had this been done, the malfunction apparently could have been analyzed by the pilot in sufficient time to affect a safe precautionary landing at home base, thereby saving a valuable wearons system unit.

3. All tactical aircraft in our inventory are subject to occasional fuel transfer malfunction. To eliminate accidents similar to this one, unit commanders must take positive and persistent measures to impress each pilot with malfunction potential and associated pilot responsibility regarding timely analysis and corrective action. Concurrently, existing policy re ejection must be presented so that each pilot recognizes there is a proper time/altitude for ejection whenever corrective action fails or an attempted landing is considered inadvisable.

4. Doctrine requires the wearing of life jackets by pilots of Wing units on all flights in tactical aircraft operating from MCAS El Toro.

5. Helicopter rescue was effected by pilots and crew of MRR(L)-362. The Helicopter Rescue Report, referred to as enclosure (9), has been submitted direct and is identified as CG, TCAS El Toro Helicopter Rescue Report 2-58 of 19Dec58.

ORIGINAL.

SPECIAL HANDLING REPUTRED in accordance with para 65 of CPNAV INST 3750.50 61: CEM: kef DEC 24 1958

6. The following additional administrative errors are noted:

a. Part I, Section A, Item 11: location should be expressed as "Lat. 33.5N, Long. 117.8W".

b. Fart I, Section A, Item 18 should read "4-In Flight"

J. d. Enemo

T. G. ENNIS

Copies to:
CMC (Gode AAP)
Buler (MA-61)
NavivaSaften (2 air mail)
CintPacFlt
ComNavairPac
GG, AirFlfffac
CG, NAS El Toro, Calif.
BAR, East Hartford, Conn.
BAP, El Segundo, Calif.
15 NeU, NAS El Centro, Calif.
GO, MAI 15 (6)
CO, MAI 15 (7)
CO, MAI 15 (8)
CO, MAI

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SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 65: OPNAVINST 3750.60

AvnSafo: JKD: vrc

DEC 1 5 1958

SECOND ENDORSEMINT on VMF (AW)-513 AAR serial 2-58 concerning FAD-1 BuNo 139106 accident occurring 19 November 1958, pilot (b)

Commanding Officer, Marine Aircraft Group-15 Chief of Naval Operations (OP-57)

(1) Commanding General, 3d Marine Aircraft Wing (2) Commanding General, Aircraft, Fleet Marine Force, Pacific (3) Commander, Naval Air Force, Pacific Fleet

(4) Chief, Bureau of Aeronautics (MA-61)

(5) Commander, U.S. Naval Aviation Safety Center

Subj: Major Aircraft Accident Report, Case of Captain (b) (6)

- 1. Forwarded, concurring with the comments, conclusions and recommendations of the Mircraft Accident Board Report and the first endorse-
- 2. This report is re-numbered as VMF(AW)-513 AAR serial 2-58. Records available to VMF(AW)-513 when they re-formed did not indicate a previous accident this calender year.
- 3. It is S.O.P. for all pilots in this command to wear life jackets on all flights from this base.
- 4. It is believed that Crash and Rescue should not be checked in Part II Section B1 as these facilities did not have any effect on the accid-
- a. The comments on the effectiveness of personal safety equipment should have been made in the Analysis Section instead of the Investigation Section.
- b. Sparch and Rescue facilities should have been discussed in the Analysis Section instead of the Investigation Section.

Copies to: Buler (MA-61) CMC (Code AAP). CinCPacFlt ComNavAirPac CG, AirFMFPac CG, 3dMAW DinC NPU, El Centro ComAvnSafCen (2cc lir Mail)

BAR, East Hartford Bar, El Segundo CO, VMF(AW)-513

FECTAL HANDLING WIRED IN ACCORDANCE WITH PARAGRAPH 654 OFNAVINST 3750 60

AvnSafO:JFT:num 9 December 1958

FIRST ENDORSEMENT on VMF(AW) -513 ACR serial 1-58 concerning FAD-1 BuNo. 139106 accident occuring 19 November 1958, pilot (b)

From: Commanding Officer, MarallwEAFITRON FIVE ONE THREE TO: Chief of Maval Operations (OF-57)

Via:

(1) Commanding Officer, Marine Aircraft Group-15 (2) Commanding General, 3d Parine Aircraft Wing

Commanding General, Aircraft, Fleet Marine Force, Pacific

Commander Naval Air Force, Facific Fleet Chief, Bureau of Aeronautics (MA-61)

Commander, U.S. Naval Aviation Safety Center

Subj: Major Aircraft Acc ent Report, Case of Captein (D) (6) USMCR

- 1. Comment number 1 is concurred in. In that the aircraft was not recovered it is impossible to determine the cause of the fuel system malfunction.
- 2. Comment number 2 is concurred in. The pilot erred in failing to monitor his internal fuel state more closely. Because of the fact that much of the fuel is carried externally and since the fuel consumption while using afterburner is very high, constant monitoring of the internal fuel state is mandatory.
- 3. A recommendation to prevent future fuel system malfunctions is not made as stated by the board (recommendation 1) since the cause of the malfunction was not determined.
- 4. The boards recommendation number 2 for the incorporation of a low fuel quantity light in the F4D-I is concurred in. If a warning light had been installed in the subject aircraft the pilots attention would have been directed to the fuel transfer malfunction in sufficient time to land safely.
- 5. The following is in reference to the boards recommendation number three. The importance of constantly monitoring the internal fuel state while transferring has been stressed during pilot indoctrination. A renewed emphasis on this subject has been effected so that constant attention to the fuel system will be paramount in each pilots mind regardless of the flight maneuvers envolved.
- 6. The pilots failure to wear a life jacket did not contribute to the accident but could easily have cost him his life. Hereafter life jackets will be worn on every flight from this base.
- 7. The failure of the life raft is being reported by separate correspondence.

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8. There is nothing in the pilot's history indicative of a deficiency as a pilot. He has had no previous accidents. He has considerable flight experience in jet aircraft (TV-2, F9F-5, F3D, F4D-1) and has proven to be a competent aviator. His actions have been mature and responsible.

9. A separate legal investigation has not been ordered as a result of the accident.

I. D. GROW

Copies to:
Buder (MA61)
CMC (Code AAP)
CinCFacFlt
ComNavAirFac
CG, AirFMFFac
CG, 3d Maw
CO, NAG-15
OinC NFU, El Centro
ComavnSafCen (2cc AirMail)
BAR, East Wartford
BAR, El Segundo
File

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SPECIAL HANDLING REQUIRED IN ACCORDING WITH PARAGRAPH 65 OFNAV INST 3750.60

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At approximately 0910U on the morning of 19 November 1958, aircraft

FAD-1, Byno 139106, hereafter referred to as WF-3, became airborne at

MCAS El Tero (Santa Ana), California on a scheduled section tactics flight

(Enclosure (3)) Enclosure (3) states that daily pre-flight inspection

of WF-3 was completed at 0730U and that the aircraft was ready for flight.

The aircraft was accorted for flight by Capt. (b) (6)

usMcR, (b) (6)

at 0845U.

.. WF-3 became airborne at MCAS, El Toro with full internal and full external fuel which amounts to a total of 8060 pounds.

At approximately 09400, some 25-30 minutes after take-off, Capt. (b)
noticed he had 2200 pounds of fuel remaining in his external tanks, but
was at a low fuel state in his main fuel tanks. An attempt was made to
return to MCAS, El Tere, but the engine flamed out at approximately 16,000
ft. and at a distance of some 10 miles south of the field. Capt. (b) (6)
elected to eject from his alreadt. He piloted the aircraft to a position
clear of all populated areas and when ever water, he ejected at an altitude
of 8500 feet. The ejection was successful and Capt. (b) was subsequently
rescued by the MCAS, El Tere rescue helicapter after approximately 5-10
rinutes in the water.

After the pilot ejected, WF-3 made a 360 degree turn to the right and crashed at sec about 14 miles WSW of Laguna Beach, California at 33 degrees, 31 minutes North, 117 degrees, 50.5 minutes West.

13

Since F4D-1 Buno 139106 was lost at sen in 375 feet of water, it is impossible to determine the extent of impact damage to the aircraft.

For reasons to be discussed in part VII of this report, the engine of F4D-1 Buno 139106 flamed out at 16,000 feet. There was no indication of damage to the circuaft prior to impact. The 360 degree turn after ejection is felt to have been caused by normal aerodynamic forces and not damage incurred by any control surface as a result of the ejection.

No attempt was made to recover FAD-1, Buno 139106 for reasons indicated in enclosures (/a) and (46).

The investigation for this accident was storted almost before the accident loccurred. The aviation safety officer was acting as the squadron operations duty officer on the morning of 19 November 1958. He heard Capt. (b) (6) call of a low fuel indication to his win man over a remote controlled unit radio transcoiver which is installed in the squadron roady room and tuned to the squadron's assigned tactical operating frequency.

Rescue operations were started at this time by the squadron duty officer, who made a telephone call to MCAS El Taro were informing them of the situation. No centact with the tower was attempted by Capt. (b) (for capt. (b) (for contacted the first than a first them of the situation. It. (b) (for contacted the first the scene until the pilot had been picked up by the helicopter. The pilot landed about five miles West of the point of impact of the mireraft.

By early afternoon on 19 November a member of the accident board arrived at the scone of the crash aboard a Newport Harbor Life duard. Service Boat stationed at Corona Del Mar, California. Only small pieces of the plastic radome had been found aftent and were recovered. These were of no value to the board. A heavy odor of JP-4 was noted at the site which had been marked by a busy placed by the U.S. Coast Guard earlier.

The pilot was picked up by the MCAS, El Toro helicopter 5 to 10 minutes after he hit the water. Also at the scene, and within five miles of the spot the pilot landed, were two rescue boats. Capt. (b) was

taken to the station dispensary at MCAS, El Toro. X-rays were taken but no apparent injuries were noted. Interregation of the pilot revealed the following facts: ENCL (5)

- Pro-flight inspection, start, and climb to altitude were normal. Fuel transfer from external tanks was normal at this time.
- 2. Total afterburner time during this flight was roughly twenty minutes.

 Total time from take-off to erash was 30-35 minutes.
- 3. After about twenty-five minutes of flight a fuel check revealed that the aircraft had 1200-1500 rounds of fuel remaining intermally and 2200 pounds of fuel remaining externally. Gapt. (b) started a turn at military rated power to allow his wingman to join and to allow his internal tanks to fill from the external tanks. Since the J-57 engine burns fuel from the main cells faster than it can be transferred from the external tanks when in afterburner operation, Capt. (b) did not consider this law reading abnormal in view of extensive afterburner operations. About five minutes later another fuel check showed about 200 pounds internal fuel and still over 2000 rounds external.
- 4. The pilot immediately reduced power to idle and honded for MCAS El Tore in a maximum range glide. Several attempts to transfer fuel were made. A check showed that each of the external tanks had an equal amount of fuel.
- 5. At 16,000 feet the internal fuel gauge read zero. The fuel boost pump failure warning light came on, followed by the main fuel pump



failure warning light, and subsequently the engine flamed out.

- Three airstarts were attempted, two in the normal fuel system and one in the manual fuel system, to be avail.
- Capt. (b) turned his circuaft toward the sea and when clear of land
- 8. All ejection and survival equipment functioned excrerly with the exception of the FK-2 life raft. The raft had a slow leak caused by the CO2 bottle connection and firing mechanism rubbing against the maft while stowed in the parachute assembly. The pilots APH-5, equired with maps strap and Hardimen retention kit, was retained by the pilot. The gilot was not wearing his life vest.

Yellow sheets and aircraft logs revealed one previous fuel system discrepancy in the preceding thirty days. This discrepancy was fuel streaming from the port external tank in flight. A total of approximately 800 pounds of fuel was lost due to this during a 1.7 hour flight. The fuel line connection at the tank was changed and no further trouble has been noted (see enclosure (7)). Fuel samples were taken from other squadren aircraft and also the refueler trucks for the purpose of determining the likelihood of fuel contemination. Results offered no proof of significant fuel contamination which could be regarded as a possible cause of the accident.

A detailed discussion was held with the Pratt-Whitney field representative and a thorough study of the history of F4D-1 fuel system

PART VII (Cont.)

failures was made.

Interregation of Capt. (b) (6) wingman disclosed little additional information. He did say however, that at no time did he notice fuel leaking from Capt. (b) (6) plane. Evel. (6)

Page 9 of /3 pages



The engine of F4D-1 Buno 139106 flamed out due to fuel starvation. A fuel indication of zero closely followed by the sequence of failure lights as related in Part VII offers ample proof of a fuel starvation flame-out.

malfunction caused the external tanks to stop transferring after normal transfer had been started. The fact has been extablished in part, VII that at the time of the flame-out and subsequent ejection there was an indication of over 2000 pounds of fuel remaining in the external tanks. Proper technique was used in the attempts to transfer this fuel but to no avail.

Since the circreft was not recovered, it is immessible to establish what component caused the failure.

By Capt. (b) (6) statement it is indicated that he lost approximately 1000 pounds of fuel during a 5-10 minute period at military rated power.

Normal fuel flow at this power setting and altitude is less than 50 pounds per minute. No fuel lenkage was noted by Capt. (b) (6) wingman. A check of Lt. (b) (6) fuel shows that at the time of the flame-out the fuel indications of the two aircraft were within three to four hundred pounds of each other. This small difference can easily be explained by the different fuel consumption of engines and varied pilot techniques of fuel management.

Since no other fuel checks were made and the gauge appears to have been working normally at the end, to wit, a reading of empty closely followed

16

PART VIII (Cont.)

by a flame-out; the board can find no satisfactory answer for this sudden fuel drop. The possibility, therefore, of a fuel gauge malfunction, at least intermittently, does exist.

The sudden problem of low interpol fuel and being unable to transfer external fuel presented a definite emergency to the pilot. His reactions to the situation and attempted corrective actions are considered proper.

Capt. (b) (7) decision to eject after flam-out, and his decision to remain with the circust until clear of all populated areas before ejection was consistant with soundren and 3dMAW policies.

FART IX - Corments and Recommendations

COMMENTS :

On the basis of the facts revealed by the investigation and the

- 1. Material failure is considered a contributing factor to this accident.

 The board concluded from the investigation that the external tanks did

 not properly transfor all their fuel. Fuel rendings as stated in

 enclosure (5) also indicate a possible fuel gauge malfunction. Since

 the aircraft was not recovered, the board cannot determine to what degree
 those malfunctions contributed to the accident.
- 2. Filot factor must be considered in this case. Because of the nature of the flight (i.e., section tactics), his attention might (b) (5)
 - (b)(5)
 - (b)(5)

The opinion of this board

(b) (5)

RECOMMENDATIONS:

As a possible means of preventing future accidents of this kind, the

- 1. Since the exact component failure in this accident is unknown, no corrective recommendations can be made.
- 2. The board recommends that a low fuel warning light be incorporated in the F4D type aircraft. Other service type high performance jet aircraft have a

PART IX (Cont.)

low fuel warning system incorporated with good results and a similar system in the F4D could have prevented this, and like accidents.

From mand sement of fuel is a function of the human element. Existing square and rescurred on this subject are adequate and no specific recommendations are made. This square has re-emphasized the necessity for each pilot to constantly menitor his fuel surply by making this item the subject of a flight safety afficer's briefing. Filots have also been reminded an existing regulation in regards to yearing of life vost regardless of intentions of over-water flight.

STATEMENT OF AIRCRAFT MAINTENANCE OFFICER

F4D-1 Bureau Number 139106 was received at this squadron on 7/16/58, with Pratt and Whitney J-57 Engine, Serial Number P627025 installed. The total time since acceptance of the aircraft was 43.5 hours, prior to the final flight. Total engine time since new was 53.1. The aircraft had flown 13.1 hours in the past month.

Investigation of the past maintenance of the subject aircraft indicated the only pilot "squawk" which would be of interest pretaining to a malfunction of the fuel system occurred on 31 October 1958, when the left external tank streamed fuel on transfer, and a loss of 800, the left external tank streamed fuel on transfer, and a loss of 800, pounds was noted on a flight of 1.7 hours. This was a direct result of removing both external tanks in order to report the Aero 7 A pylon racks on the 30th of October. This discrepancy was corrected by repositioning the fuel transfer hose on the external tank and the aircraft flew 10 sorties, for a total of 13.1 hours with no further malfunctions reported on the fuel system.

The fuel transfer system in the F4D is basically simple. However, items noted in Douglas Aircraft Service Reports indicate possible areas of malfunction of the transfer system. The transfer system is initiated when the pilot actuates an external fuel transfer switch located on the right hand console in the cockait. This in four opens a transfer valve, which allows 9th stage compressor air to be directed to both external which allows 9th stage compressor air to be directed to both external transfer of fuel. Should this valve fail to open due to an electrical failure, a spring loaded solanoid, forces it to

STATEMENT OF AIRCRAFT MAINTENANCE OFFICER (Cont.)

the open side, thus making it a fail safe type valve. Should the fuel level control valves, located in both left, and right main cells fail to open, fuel will not be transferred. The valves operate on a float type principal, and when the fuel level drops 2 to 3 inches the valves open allowing fuel to be admitted from the external source.

There is a history of sticking of the override weights on the fuel level control valves in early airplanes, but in each case only one of the two external tanks failed to transfer. However, there is a probability that multiple failures could result in failure to transfer from both tanks. The same situation might apply should the vacuum relief valve located on the upper part of the nose section of the external, tank fail to close, which would cause a lose of tank pressurization.

If the 9th stage air line and/or associated plumbing which pipes compressor air to the external tanks for pressurization became disconnected or ruptured a failure to transfer would result. Failure to transfer could also occur if only one tank pressure line became separated. The amount of air required to pressurize, and at the same time overcome the leak of a rupture would not be available unless the engine was operated at very high power settings. At altitude it is questionable that transfer could be effected at all in the event of a pressure line rupture.

This squadron is operating on the Planned Progressive Maintenance

Page 2 of 3

SPECIAL HANDLING REQUEST

STATEMENT OF AIRCRAFT MAINTENANCE OFFICER (Cont.)

System, by authority of (Buner msg 072044Z) March 58, and PFM cards 54, through 58, were completed on 18 November. The external fuel system was inspected and checked on cards 39 and 41, completed on 10/17/58. No other malfunctions have been noted on the "Yellow Sheets" pertaining to the fuel system other than those previously descirbed,

In conclusion, a malfunction of the external fuel system could have occured. A malfunction of the fuel quantity indicating system could also have occured, for, as noted in the pilots statement, he reported a sudden loss from 1500 pounds to 200 pounds, of internal fuel in an estimated 5 to 7 minutes, which in not normal fuel consumption in military power at his altitude. Should the fuel quantity indicator have stuck in one position previously he would get an erroneous reading.

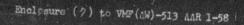
An examination of all other squadron aircraft uncovered no significant fuel contamination or transfer problems.

Since salwage of the aircraft was not deemed occurrenced or feasable, and in view of the milets statement, the contribution to the accident of material failure and/or maintenance error such the considered undetermined.

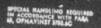
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presjor USMC

Aviation Experience: Over 20 years N/C Maintenance. Credibility - Very Good







PILOT'S HISTORY

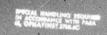
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Enclosure (8) to VMF(AW)-513 AAR 1-58

MARINE ALL WEATHER FIGHTER SQUADRON 1513 MARINE AIRCRAFT GROUP 15 30 MARINE AIRCRAFT WING, AIRSHFFAC MCAS, EL TORO (SANTA ANA), CALIFORNIA

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ENCLOSURE (2) TO VMF(AW)-513 AAR 1-58



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SECTION C - PHYSIOLOGICAL, REMAN ENGINEERING, DESIGN, SOCIO-PSYCHOLOGICAL, AND TRAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT

MIE OF INDIVIDUAL' flast, first, middle) Check E-Established, S-Suspected, or P-Present for each factor selected. Additional SNION plain sheets will be used for the supporting account of items checked below. Identify bach statement with the factor and section identification (e.g., Cl. Cl. atc.).

Attach all sheets pertaining to these factors to this form upon completion. ESP J FACTORS ESP SOC10 PSYCHOLOGICAL: (Exotional atress from duty sources) 29. Expeditings/Delays 1. Physically incapacitated in flight 30. Weather 2. "G" forens 31. Mechanical Problems Faclosure (3) 3. Environmental stress - External 32. Social and working relationships - Internal 5. Dyabarism/explosive decompression 33. Personal comfort 6. Dist 34. Regulations 35. Facilities 7. Fatigue 36. Navigation 8. Hypoxia 9. Related illness 37. Duty assignment 10. Vertigo/Disorientation/Illusions 38. Personality traits 11. Hyperventilation NON-STRESS FACTORS: 12. Drugs 39. Faulty attention 40. Poor judgement Saclosure (3) 13. Physical state 14. OTHER: 41. Forgetfulness 42. OTHER SOCIO-PSYCHOLOGICAL FACTORS HUMAN ENGINEERING AND DESIGN: 15. Personal equipment 16. Displays and/or controls 17. Work arrangement Enclosure (3) 18. Working environment 19, flabit interference TRAINING FACTORS: 20. OTHER: 44. Emergency Procedures training 45. Survival and rescue training 21. Pregnancy. 46. Befresher training 22. Illness or death 23. Argumenta 24. Elated/Depressed state 25. Personal habits . Drinking - Gumbling SECTION D . AIR CREW DATA (fill in where applicable) 20.7 hrs. 7. Total time in model 1. Flight time past 30 days 2.6 hra. 2. Flight time last 24 hours B. Number of days grounded last month, give reason Number of flights in last 24 hours 4. Time at controls this flight 9. Number of and dates of previous accidents 5. Number of hours daty last 34 hours 8 mrs. 6. Total flight time 550.0 hrs. SECTIONE . CONTRIBUTING FACTORS AND THEIR ANALYSES (As condensed from Part 1, Seet. D and Part VIII of the AM). NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A. i.e. 15(a). Actack failure of proper transfer of fuel from the external tanks to the sain fuel cell a contributing cause of this accident. In addition to this me information to substantiate these possibilities as the sireraft was (b) (5) (b) (5)

However, it is difficult to be too critical as the pilot was performing tection! manouvers which would prevent his focusing his entire attention on only the fuel status.

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"SPROIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 65 OPMAY INST 3750.60" F4D-1 Bureau #139106 19 Tovember 1958 MCAS, El Toro

MEDICAL OFFICER'S MARRATIVE ACCOUNT:

On 19 Wavember 1958 at approximately 0919, CAPT (b) departed %CAS, El 5. Tore (Santa ana), California, on a scheduled section tactics in an E4D-1 aircraft, Eurema number 139106. Accompanying CAPT (b) was LT (b) (6) CAPT

(b) was the section leader.

Prior to takeoff all proflight checks had been normal. With both internal and external fuel cells being full, the aircraft would be carrying over 8,000 pounds of fuel. During the tactics hop considerable afterburner was used and after being airborno about 20 minutes CAPT (b) noted he had approximately 2200 pounds remaining in his external tanks and about 1500 pounds in his main fuel cell. He did not consider this unusual while using afterburner as fuel is being consumed at a more rapid rate from the main fuel cell than it can be transferred from the external tanks. He checked his fuel gauge approximately five minutes later (during this period the afterburner was in uso) and noted 2200 pounds in his external fuel tanks and approximately 200 pounds in his main fuel cell. Subsequent attempts to transfer fuel were unsuccessful. CAPT GRAY then reduced the throttle to idle, notified his wingman of the low fuel state and established a maximum range glide towards MCAS, El Toro. At approximately 16,000 feet the aircraft flamed out. Three attempts at a re-light were unsuccessful and CAPT (b) elected to abandon the aircraft. He turned back towards the ocean and notified his wingman by hand signal that he was going to eject. At 8500 feet and about 190 knots a successful ejection was made. LT (6) notified El Toro tower of the ejection and gave the geographical location. LT (b) (6) orbited the area until the air-sea rescue helicopter arrived and then returned to El Toro.

The ejection went smoothly without difficulty and the parachute was developed at about 8000 feet. CAPT (b) an experienced parachutist, noted report severe occillations at first but this stopped without dampening as he reached lower altitudes. CAPT(b) (6) removed his life raft prior to landing in the ocean and released himself from his parachute harness as his feet touched the water. He was not wearing a life vest us he had forgetten to put it on prior to the hop. He inflated his life raft, but found that it leaked badly. Fortunately, the air-sea rescue helicopter arrived within five or ten minutes after CaPT(b) had landed in the ocean some five miles from shore. A normal pick up with a sling was made by the helicopter without difficulty. CAPT(b) was then brought to the Station Hespital at MCAS. El

(b) (6)

(b) (6)

no was grounded for 34 hours for psychological, reasons and then returned to full duty.

water CaPT (b) abandened the aircraft, it made a slew turn, struck the water and disappeared in less than a minute. Small portions of the plastic radems were recevered the same day near where the aircraft struck the water. A heavy oder of JP-4 was also noted where the aircraft struck the water (the site had been marked with a bucy by the U. S. Coast Guard).

ENCLOSURE (1) TO NOR 22-59.

MCAS, El Tore



"SPECIAL HAVDLING REQUIRED IT ACCORDANCE WITH PARA 65 OPTAY INST 3750.60" F4D-1 Bureau #139106 19 Wovember 1958 MCaS, El Tero

CONCLUSIONS:

This accident was the result of mechanical failure of the aircraft and pilot error.

RECOMMENDATIONS:

- 1. A warning light should be installed in this aircraft which would denote a low fuel state in the main fuel cell when it occurs.
- 2. all life rafts should be carefully inspected and inflated to test for loaks whenever the parachas is repacked.
 - 3. All pilots should wear life vests if there is a possibility they may be over water. This of cours: " squadron policy in VMF(AW)-518 and usually is checked by the squadron operations duty officer. A lapse of memory on the part of CAPT GRAY is the reason for his not wearing his life yest.

F4D-1 Burodu #139106 10 Wovember 1958 MCAS, El Toro "SPECIAL HAVILING REQUIRED IN ACCORDANCE WITH PARA 65 OPPAY INST 3750.50" Therefore, impreper fuel casual factor in this accident.
Evaluation of this point is difficult because, in addition, machanical failure was present. Thability to transfor fuck from the external tanks to the main fuel cell was a contributing factor of this accident.